House Engrossed

State of Arizona
House of Representatives
Forty-fifth Legislature
Second Regular Session
2002

CHAPTER 139

HOUSE BILL 2137

AN ACT

AMENDING SECTIONS 20-1051, 20-1054, 20-1057 AND 20-1065, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1078; AMENDING SECTION 20-2318, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE SERVICES ORGANIZATIONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-1051, Arizona Revised Statutes, is amended to read:

20-1051. Definitions

In this article, unless the context otherwise requires:

~~1. "Basic health care services" means those health care services that an enrollee might reasonably require as determined by the director of the department of insurance, with advice from the director of the department of health services, in order to be maintained in good health and that include at least the following:~~

~~(a) Emergency care.~~

~~(b) Inpatient hospital and physician care.~~

~~(c) Outpatient medical services that include laboratory, radiological and other special diagnostic examinations, and suitable alternatives to active care in a general hospital such as in skilled nursing homes or organized home care programs, but not including care that is solely custodial in purpose.~~

~~2.~~ 1. "Director" means the director of the department of insurance.

~~3.~~ 2. "Enrollee" means an individual who has been enrolled in a health care plan.

~~4.~~ 3. "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee and setting out the coverage to which the enrollee is entitled.

~~5.~~ 4. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

~~6.~~ 5. "Health care plan" means any contractual arrangement whereby any health care services organization undertakes to provide directly or to arrange for all or a portion of ~~designated basic~~ CONTRACTUALLY COVERED health care services and to pay or make reimbursement for any remaining portion of the ~~basic~~ health care services on a prepaid basis through insurance or otherwise. A health care plan shall include ~~basic~~ THOSE health care services REQUIRED IN THIS ARTICLE OR IN ANY RULE ADOPTED PURSUANT TO THIS ARTICLE.

~~7.~~ 6. "Health care services" means ~~any~~ services for the purpose of diagnosing, preventing, alleviating, curing or healing human illness or injury.

~~8.~~ 7. "Health care services organization" means any person that undertakes to conduct one or more health care plans. Unless the context otherwise requires, health care services organization includes a provider sponsored health care services organization.

~~9.~~ 8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health care services organization including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

~~10.~~ 9. "Network plan" means health care services that are provided by a health care services organization under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers under contract with the health care services organization.

~~11.~~ 10. "Person" means any natural or artificial person including, but not limited to, individuals, partnerships, associations, providers of health care, trusts, insurers, hospital or medical service corporations or other corporations, prepaid group practice plans, foundations for medical care and health maintenance organizations.

~~12.~~ 11. "Provider" means any physician, hospital or other person that is licensed or otherwise authorized to furnish health care services in this state.

~~13.~~ 12. "Provider sponsored health care services organization" means a provider sponsored organization that provides at least one health care plan only to medicare beneficiaries under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

~~14.~~ 13. "Provider sponsored organization" means an entity that:

(a) Is a legal aggregation of providers that operate collectively to provide health care services to medicare beneficiaries under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act, sections 1851 through 1859).

(b) Acts through a licensed firm or corporation that has authority over the entity's activities and responsibility for satisfying the requirements of this article relating to the operation of a provider sponsored health care services organization.

(c) Provides a substantial proportion of the health care services required to be provided under the medicare-plus-choice program established under the balanced budget act of 1997 (42 United States Code sections 1395w-21 through 1395w-28 and title XVIII, part C of the social security act,

sections 1851 through 1859) directly through providers or affiliated groups of providers.

Sec. 2. Section 20-1054, Arizona Revised Statutes, is amended to read:

20-1054. Issuance of certificate of authority

A. Issuance of a certificate of authority shall be granted within the time prescribed in section 20-216 by the director if the director is satisfied that the following conditions are met:

1. The persons responsible for conducting the affairs of the health care services organization are competent and trustworthy and are professionally capable of providing or arranging for the provision of health and medical services being offered.

2. The health care services organization constitutes an appropriate mechanism to achieve an effective health care plan~~, in accordance with rules that are~~ PURSUANT TO THIS TITLE AND ANY RULE THAT IS adopted by the director ~~and that include at least the basic health care services~~.

3. The health care services organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the director may consider:

(a) The financial soundness of the health care plan's arrangements for health care services and the schedule of charges used in connection therewith.

(b) Any agreement with an insurer, a hospital or a medical service corporation, a government or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan.

(c) Any agreement with providers for the provision of health care services.

4. Each officer responsible for conducting the affairs of the health care services organization has filed with the director, subject to the director's approval, a fidelity bond in the amount of fifty thousand dollars.

B. A certificate of authority prescribed by subsection A of this section shall expire at midnight on June 30 next following the date of issuance or previous renewal. If the health care services organization remains in compliance with this article and has paid the fee prescribed by section 20-167 respecting renewal of a certificate of authority to a hospital and medical service corporation, its certificate shall be renewed.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 3. Section 20-1057, Arizona Revised Statutes, is amended to read:

20-1057. Evidence of coverage by health care services organizations; renewability; definitions

A. Every enrollee in a health care plan shall be issued an evidence of coverage by the responsible health care services organization.

B. Any contract, except accidental death and dismemberment, applied for that provides family coverage shall, as to such coverage of family members, also provide that the benefits applicable for children shall be payable with respect to a newly born child of the enrollee from the instant of such child's birth, to a child adopted by the enrollee, regardless of the age at which the child was adopted, and to a child who has been placed for adoption with the enrollee and for whom the application and approval procedures for adoption pursuant to section 8-105 or 8-108 have been completed to the same extent that such coverage applies to other members of the family. The coverage for newly born or adopted children or children placed for adoption shall include coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the contract may require that notification of birth, adoption or adoption placement of the child and payment of the required premium must be furnished to the insurer within thirty-one days after the date of birth, adoption or adoption placement in order to have the coverage continue beyond the thirty-one day period.

C. Any contract, except accidental death and dismemberment, that provides coverage for psychiatric, drug abuse or alcoholism services shall require the health care services organization to provide reimbursement for such services in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital.

D. No evidence of coverage or amendment to the coverage shall be issued or delivered to any person in this state until a copy of the form of the evidence of coverage or amendment to the coverage has been filed with and approved by the director.

E. An evidence of coverage shall contain a clear and complete statement if a contract, or a reasonably complete summary if a certificate of contract, of:

1. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

2. Any limitations of the services, kind of services, benefits or kind of benefits to be provided, including any deductible or copayment feature.

3. Where and in what manner information is available as to how services may be obtained.

4. The enrollee's obligation, if any, respecting charges for the health care plan.

F. An evidence of coverage shall not contain provisions or statements that are unjust, unfair, inequitable, misleading or deceptive, that encourage misrepresentation or that are untrue.

G. The director shall approve any form of evidence of coverage if the requirements of subsections E and F of this section are met. It is unlawful to issue such form until approved. If the director does not disapprove any such form within forty-five days after the filing of the form, it is deemed approved. If the director disapproves a form of evidence of coverage, the director shall notify the health care services organization. In the notice, the director shall specify the reasons for the director's disapproval. The director shall grant a hearing on such disapproval within fifteen days after a request for a hearing in writing is received from the health care services organization.

H. A health care services organization shall not cancel or refuse to renew an enrollee's evidence of coverage that was issued on a group basis without giving notice of the cancellation or nonrenewal to the enrollee and, on request of the director, to the department of insurance. A notice by the organization to the enrollee of cancellation or nonrenewal of the enrollee's evidence of coverage shall be mailed to the enrollee at least sixty days before the effective date of such cancellation or nonrenewal. The notice shall include or be accompanied by a statement in writing of the reasons as stated in the contract for such action by the organization. Failure of the organization to comply with this subsection shall invalidate any cancellation or nonrenewal except a cancellation or nonrenewal for nonpayment of premium, for fraud or misrepresentation in the application or other enrollment documents or for loss of eligibility as defined in the evidence of coverage. A health care services organization shall not cancel an enrollee's evidence of coverage issued on a group basis because of the enrollee's or dependent's age, except for loss of eligibility as defined in the evidence of coverage, sex, health status-related factor, national origin or frequency of utilization of ~~basic~~ health care services of the enrollee. An evidence of coverage issued on a group basis shall clearly delineate all terms under which the health care services organization may cancel or refuse to renew an evidence of coverage for an enrollee or dependent. Nothing in this subsection prohibits the cancellation or nonrenewal of a health benefits plan contract issued on a group basis for any of the reasons allowed in section 20-2309. A health care services organization may cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis only for the reasons allowed by subsection N of this section.

I. A health care plan that provides coverage for surgical services for a mastectomy shall also provide coverage incidental to the patient's covered mastectomy for surgical services for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications for all stages of the mastectomy, including lymphedemas, and

at least two external postoperative prostheses subject to all of the terms and conditions of the policy.

J. A contract that provides coverage for surgical services for a mastectomy shall also provide coverage for mammography screening performed on dedicated equipment for diagnostic purposes on referral by a patient's physician, subject to all of the terms and conditions of the policy and according to the following guidelines:

1. A baseline mammogram for a woman from age thirty-five to thirty-nine.

2. A mammogram for a woman from age forty to forty-nine every two years or more frequently based on the recommendation of the woman's physician.

3. A mammogram every year for a woman fifty years of age and over.

K. Any contract that is issued to the enrollee and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of any child legally adopted by the enrollee if all the following are true:

1. The child is adopted within one year of birth.

2. The enrollee is legally obligated to pay the costs of birth.

3. All preexisting conditions and other limitations have been met and all deductibles and copayments have been paid by the enrollee.

4. The enrollee has notified the insurer of the enrollee's acceptability to adopt children pursuant to section 8-105 within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

L. The coverage prescribed by subsection K of this section is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29 but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The enrollee adopting parents shall notify their health care services organization of the existence and extent of the other coverage. A health care services organization is not required to pay any costs in excess of the amounts it would have been obligated to pay to its hospitals and providers if the natural mother and child had received the maternity and newborn care directly from or through that health care services organization.

M. Each health care services organization shall offer membership to the following in a conversion plan that provides the basic health care benefits required by the director:

1. Each enrollee including the enrollee's enrolled dependents leaving a group.

2. Each enrollee and the enrollee's dependents who would otherwise cease to be eligible for membership because of the age of the enrollee or the enrollee's dependents or the death or the dissolution of marriage of an enrollee.

N. A health care services organization shall not cancel or nonrenew an evidence of coverage issued to an individual on a nongroup basis, including a conversion plan, except for any of the following reasons and in compliance with the notice and disclosure requirements contained in subsection H of this section:

1. The individual has failed to pay premiums or contributions in accordance with the terms of the evidence of coverage or the health care services organization has not received premium payments in a timely manner.

2. The individual has performed an act or practice that constitutes fraud or the individual made an intentional misrepresentation of material fact under the terms of the evidence of coverage.

3. The health care services organization has ceased to offer coverage to individuals that is consistent with the requirements of sections 20-1379 and 20-1380.

4. If the health care services organization offers a health care plan in this state through a network plan, the individual no longer resides, lives or works in the service area served by the network plan or in an area for which the health care services organization is authorized to transact business but only if the coverage is terminated uniformly without regard to any health status-related factor of the covered individual.

5. If the health care services organization offers health coverage in this state in the individual market only through one or more bona fide associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

O. A conversion plan may be modified if the modification complies with the notice and disclosure provisions for cancellation and nonrenewal under subsection H of this section. A modification of a conversion plan that has already been issued shall not result in the effective elimination of any benefit originally included in the conversion plan.

P. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who was enrolled in a health care plan shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the health plan within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with the provisions of subsection P of this section including:

1. Conditions of eligibility.
2. Coverage of dependents.
3. Preexisting conditions.
4. Termination of insurance.
5. Probationary periods.
6. Limitations.
7. Exceptions.
8. Reductions.
9. Elimination periods.
10. Requirements for replacement.
11. Any other conditions of evidences of coverage.

R. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The health care services organization shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.
2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.
3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.
4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.
5. Except as described in subsection S of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

S. Nothing in subsection R of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

4. Insulin preparations and glucagon.

5. Insulin cartridges.

6. Drawing up devices and monitors for the visually impaired.

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.

11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.

12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

U. Nothing in subsection T of this section:

1. Entitles a member or enrollee of a health care services organization to equipment or supplies for the treatment of diabetes that are not medically necessary as determined by the health care services organization medical director or the medical director's designee.

2. Provides coverage for diabetic supplies obtained by a member or enrollee of a health care services organization without a prescription unless otherwise permitted pursuant to the terms of the health care plan.

3. Prohibits a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

V. Any contract or evidence of coverage that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection W of this section or medical literature that meets the criteria prescribed in subsection W of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Notwithstanding section 20-1057.02, require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract or evidence of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

W. For the purposes of subsection V of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American medical association drug evaluations, a publication of the American medical association.

(b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

(c) The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the United States department of health and human services as acceptable peer reviewed medical literature pursuant to section 186(t)(2)(B) of the social security act (42 United States Code section 1395x(t)(2)(B)).

X. A health care services organization shall not issue or deliver any advertising matter or sales material to any person in this state until the health care services organization files the advertising matter or sales material with the director. This subsection does not require a health care services organization to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the health care services organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any penalties prescribed in this title. At least five days before issuing an order pursuant to this subsection, the director shall provide the health care services organization with a written notice of the basis of the order to provide the health care services organization with an opportunity to cure the alleged deficiency in the advertising matter or sales material within a single five day period for the particular advertising matter or sales material at issue. The health care services organization may appeal the director's order pursuant to title 41, chapter 6, article 10. Except as otherwise provided in this subsection, a health care services organization may obtain a stay of the effectiveness of the order as prescribed in section 20-162. If the director certifies in the order and provides a detailed explanation of the reasons in support of the certification that continued use of the advertising matter or sales material poses a threat to the health, safety or welfare of the public, the order may be entered immediately without opportunity for cure and the effectiveness of the order is not stayed pending

the hearing on the notice of appeal but the hearing shall be promptly instituted and determined.

Y. Any contract or evidence of coverage that is offered by a health care services organization and that contains a prescription drug benefit shall provide coverage of medical foods to treat inherited metabolic disorders as provided by this section.

Z. The metabolic disorders triggering medical foods coverage under this section shall:

1. Be part of the newborn screening program prescribed in section 36-694.

2. Involve amino acid, carbohydrate or fat metabolism.

3. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues.

4. Require specially processed or treated medical foods that are generally available only under the supervision and direction of a physician who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

AA. Medical foods eligible for coverage under this section shall be prescribed or ordered under the supervision of a physician licensed pursuant to title 32, chapter 13 or 17 as medically necessary for the therapeutic treatment of an inherited metabolic disease.

BB. A health care services organization shall cover at least fifty per cent of the cost of medical foods prescribed to treat inherited metabolic disorders and covered pursuant to this section. An organization may limit the maximum annual benefit for medical foods under this section to five thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

CC. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

DD. For the purposes of:

1. This section:

(a) "Inherited metabolic disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program prescribed in section 36-694.

(b) "Medical foods" means modified low protein foods and metabolic formula.

(c) "Metabolic formula" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

(d) "Modified low protein foods" means foods that are all of the following:

(i) Formulated to be consumed or administered enterally under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17.

(ii) Processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

(iii) Administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation.

(iv) Essential to a person's optimal growth, health and metabolic homeostasis.

2. Subsection B of this section, "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under the age of eighteen years.

Sec. 4. Section 20-1065, Arizona Revised Statutes, is amended to read:

20-1065. Suspension or revocation of certificate of authority; penalties

A. The director may suspend or revoke any certificate of authority issued to a health care services organization under this article if the director finds that any of the following conditions exists:

1. The health care services organization is operating significantly in contravention of its basic organizational documents or in a manner contrary to that described in, and reasonably inferred from, any other information submitted under section 20-1053.

2. The health care services organization issues evidences of coverage which do not comply with the requirements of section 20-1057.

3. The health care plan does not ~~provide or arrange for basic health care services as determined by the director of the department of insurance, with advice from the director of the department of health services~~ CONSTITUTE AN APPROPRIATE MECHANISM TO ACHIEVE AN EFFECTIVE HEALTH CARE PLAN PURSUANT TO THIS TITLE OR ANY RULE THAT IS ADOPTED BY THE DIRECTOR.

4. The health care services organization can no longer be expected to meet its obligations to enrollees or prospective enrollees.

5. The health care services organization, or any authorized person on its behalf, has advertised or merchandised its services in an untrue, misleading, deceptive or unfair manner.

6. The health care services organization has failed to substantially comply with this article OR ANY RULE THAT IS ADOPTED PURSUANT TO THIS ARTICLE.

7. The health care services organization is in unsound condition or in such condition as to render its further transaction of business in this state hazardous to its enrollees or to the residents of this state.

B. When the certificate of authority of a health care services organization is suspended the health care services organization shall not enroll, during the period of such suspension, any additional enrollees except newborn children or other newly acquired dependents of existing enrollees and shall not engage in any advertising or solicitation whatsoever.

C. When the certificate of authority of a health care services organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to conclude its affairs and shall conduct no further business except as may be essential to the orderly conclusion of solicitation. The director, by written order, may permit such further operation of the organization as the director may find to be in the best interest of enrollees to the end that enrollees shall be afforded the greatest practical opportunity to obtain continuing health care coverage.

D. Notwithstanding subsections B and C of this section, a health care services organization which has had its certificate of authority denied, suspended or revoked is entitled to a hearing pursuant to title 41, chapter 6, article 10 and, except as provided in section 41-1092.08, subsection H, is entitled to judicial review pursuant to title 12, chapter 7, article 6.

E. If after a hearing the director finds grounds pursuant to subsection A of this section to suspend or revoke a health care services organization's certificate of authority, the director may impose, in lieu of or in addition to that suspension or revocation, the following civil penalties that shall be remitted to the state treasurer for deposit in the state general fund:

1. For unintentional violations, not more than one thousand dollars for each violation and not more than an aggregate of ten thousand dollars in any six month period.

2. For intentional violations, not more than five thousand dollars for each violation and not more than an aggregate of fifty thousand dollars in any six month period.

F. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

Sec. 5. Title 20, chapter 4, article 9, Arizona Revised Statutes, is amended by adding section 20-1078, to read:

20-1078. Rules

THE DIRECTOR MAY ADOPT RULES PURSUANT TO TITLE 41, CHAPTER 6 TO CARRY OUT THIS ARTICLE.

Sec. 6. Section 20-2318, Arizona Revised Statutes, is amended to read:

20-2318. Mandatory coverage prohibited

Notwithstanding any law to the contrary, the basic health benefit plan is not subject to the requirements of section 20-461, subsection A, paragraph 16 and subsection B, section 20-826, subsections C, D, E, F, H, I, J and K, sections 20-841, 20-841.01 and 20-841.02, section 20-1051, ~~paragraphs 1 and 5~~ PARAGRAPH 4, section 20-1057, subsections B, C, I, J, K, L and M, section 20-1402, subsection A, paragraphs 2, 4, 5, 6, 7 and 8, section 20-1404, subsections E, F, G, H, I and J and sections 20-1406, 20-1406.01, 20-1406.02 and 20-1408.

APPROVED BY THE GOVERNOR MAY 6, 2002.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 7, 2002.

Passed the House April 8, 2002,

by the following vote: 35 Ayes,

15 Nays, 10 Not Voting

Speaker of the House

Norman L. Moore

Chief Clerk of the House

Passed the Senate April 30, 2002,

by the following vote: 27 Ayes,

0 Nays, 3 Not Voting

Randall Grant

President of the Senate

Charmin Billington

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

30 day of April, 2002,

at 2:56 o'clock P M.

Sandra Kay

Secretary to the Governor

Approved this 6 day of

May, 2002,

at 11:10 o'clock A M.

Jane Dee Hull

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 7 day of May, 2002,

at 3:13 o'clock P M.

Betsey Bayless

Secretary of State

H.B. 2137